Electronic Funds Transfer and Electronic Remittance Advice

MCO	Website	Contact Number	Email
Amerigroup	EFT: https://solutions.caqh.org/bpas/Default.aspx?ReturnUrl=/bpas/default.aspx/%22 ERA: www.Availity.com	(844) 815-9763 (800) 454-3730	EFT help: efthelp@enrollhub.caqh.org For ERA, submit email / ticket: https://www.availity.com/about-us/contact-us
Coordinated Care	www.payspanhealth.com	(877) 331-7154	ProviderSupport@payspanhealth.com
Molina Healthcare	https://providernet.adminisource.com/Start.aspx	(877) 389-1160	wco.provider.registration@emdeon.com
UnitedHealthcare Community Plan	https://www.uhcprovider.com/en/claims-payments-billing/electronic-payment-statements.html	(877) 620-6194	n/a

HCA IMC Service Encounter Reporting Instructions (SERI)

In order to receive federal match for Medicaid services, the Health Care Authority is required under CFR438.818 to ensure that all encounter data complies with HIPAA security and privacy standards. **CFR also requires that providers accurately prepare claims using applicable coding rules and guidelines.** HCA must also guarantee that encounter data is validated for accuracy and completeness; and changes in the IMC SERI guide will ensure that all encounter data is HIPAA and regulatory compliant.

The most current SERI Guide and interim guidance issued by HCA between SERI Guide updates can be found:

https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri

Evidence-Based Practice Codes

What are Evidence-Based Practice (EBP) codes and how are they used?

EBP codes are specially designated identifiers on a claim or encounter that are used to report specific research, or evidence-based practices for children's public mental health care provided by licensed or certified mental health providers to children 18 and under in Washington State. EBP encounter data is used for reporting to the legislature and other reporting requirements related to the provision of mental health services to children.

How should providers report EBPs under IMC?

The rules for coding and submitting EBPs under IMC are slightly different:

- The EBP code must be reported as a nine-digit number beginning with '860'. The next three digits must represent the appropriate EBP code as outlined in the Evidence-Based Practices Reporting Guide. The last three digits must be reported as '000'.

Example: 860163000 should be used when reporting Child-Parent Psychotherapy

- Report one EBP code per encounter in the 2300 REF02 Prior Authorization field of the standard 837 file submission.
- The REF01 field should contain the 'G1' qualifier (prior authorization).
- The REF02 field should contain the nine-digit EBP code.

Example: REF*G1*860163000

Evidence-Based Practice Codes

Will MCOs validate EBP codes on encounters and claims?

Yes. You should check with each MCO for specific validations that might apply. In general you should be ensuring the following:

- The value must match a valid 9 digit EBP code: Begins with an 860, followed by a valid 3 digit EBP code and ending with 000.
- The EBP code should only be used in conjunction with a valid CPT code per the Evidence-Based Practices Reporting Guide (under the "Eligible Encounter Codes" section).

Evidence-Based Practice Reporting Guides and additional information about EBPs can be found here:

https://www.hca.wa.gov/assets/program/ebp-reporting-guides.pdf

Behavioral Health Supplemental Data

This is the non-encounter data that was created in 2016 to replace and combine the TARGET and CIS non-encounter data. The data is needed by HCA in order to meet SAMHSA block grant reporting requirements.

Changes effective January 1, 2020:

- Healthcare Authority has released an updated Behavioral Health Supplemental Transaction Data Guide. The guide along with a list of changes from the older versions is available on HCA website: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/contractor-and-provider-resources
- All licensed and certified BHAs contracted with the MCOs/BH-ASOs are required to collect this data starting January 1, 2020.
- MCOs and BH-ASOs **must begin submitting data to HCA** no later than October 1, 2020 for Washington to be compliant with the SAMHSA CAP.
- Currently, MCOs are determining a method to collect this data from providers. Our goal is to implement systems/processes that are as similar as possible to minimize the burden on providers. In the meantime, **providers should use** the final HCA guide to begin enhancing their own systems in order to be ready to collect such data.

Prior Authorizations

Prior Authorization Requests

- Prior Authorization of covered services allows for determination of medical necessity prior to rendering of a service.
- The MCO's follow HCA contractual requirements on standard and urgent response times:
  - Standard: 5 days – 14 days
  - Urgent: 24 hrs – 72 hrs
- Turn around times are extended, with provider notification, if additional information is needed. To avoid delays, please submit complete information with the initial request.

MCO Combined Prior Auth Grid

Behavioral Health Provider Services Reference Guide

	Prior Authorization Required? *Length of Initial and Continued stay Authorization *Please send current (within past 7 days) clinical information to support initial request for "bedded" services. Interval update to recent as*				
Service Type and Description	**Amerigroup**	**CHPW**	**Coordinated Care**	**Molina**	**United**
Acute Inpatient Care – Mental Health and SUD • Acute Psychiatric Inpatient; Evaluation and Treatment • Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital • Inpatient Acute Withdrawal (Detoxification) ASAM 4.0 * Members admitted on an ITA are reviewed for change in legal status, confirmation of active treatment and transition of care needs. **If ITA, please attach court documents.**	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days* *Initial and concurrent for ITAs is 14 days.*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Initial: 3-5 days*	**No.** Emergent admissions require notification only within 1 business day followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Transitions of Care/Health Home Care coordinator.** ** Initial and concurrent: 3-5 days*	**No.** Emergent admissions require notification only within 24 hours followed by concurrent review. **Coordinate with Transitions of Care/Health Home Care coordinator.** **Authorization length segments:** ** **Voluntary admissions** - Initial and continued stay: 3-5 days (or Medical Director discretion)* ** **ITA admissions** – Initial for 72 hours, then dependent on further commitment will authorize 7 day increments. Upon confirmation of 90 day commitment, will authorize 14 day increments (or at Medical Director discretion).*	**No.** Emergent Acute admissions require notification only within 24 hours followed by concurrent review. Voluntary Admission requires initial review within 24 hours of admission. **Coordinate with Whole Person Care/Health Home Care coordinator.** **Initial: 3-5 days*

Amerigroup Prior Authorization Process

- Confirm if services require prior authorization on our website, https://providers.amerigroup.com/Pages/PLUTO.aspx
- Requests can be submitted via telephone, fax or online
- Providers are notified of authorization decisions via phone or fax
- Providers and members receive faxed and written notice of denial decisions

Issues with obtaining a prior authorization can be directed:

Kathleen Boyle, Director of Practice Integration:

Kathleen.Boyle2@Amerigroup.com
206-482-5523

How to Request a Prior Authorization

Portal: https://www.availity.com

Prior authorization forms are online: :
Amerigroup.com/Washington/Providers/Forms

Initial Inpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Concurrent Review
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Outpatient Prior Authorization
Telephone: 1-800-454-3730
Fax: 1-877-434-7578

Address:
705 5th Avenue S., Ste 300
Seattle, WA 98104

Coordinated Care Prior Authorization

- Use the Pre-Auth Check Tool on our website to determine if PA is required
  - Not a guarantee of payment, please verify benefit coverage/limitations in the HCA guides
  - Emergency stabilization services are exempt
- PA Requests and General Information:
  - Fax form which can be found on our website
- Covered services by OON providers:
  - When continuity of care applies, members are able to access care up to 90 days with previous provider
  - PA is required for many covered services, excluding urgent/emergent

Are services being performed in the emergency department or urgent care center or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☑ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Are professional services being rendered in the home? (professional services do not include the delivery of DME, orthotics, prosthetics, or supplies).	○	◉
Are anesthesia being rendered for pain management or dental surgery?	○	◉
Are oral surgeon services being rendered in office?	○	◉

Enter the code of the service you would like to check:

Code... Check

Coordinated Care Prior Authorization

- Prior Authorization Check Tool
  - https://www.coordinatedcarehealth.com/providers/preauth-check/medicaid-pre-auth.html
- Prior Authorization General Information:
  - https://www.coordinatedcarehealth.com/providers/resources/prior-authorization.html
- Prior Authorization and Concurrent Review Forms
  - https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
    - Choose “Behavioral Health Forms and Guides”
- Request PA in one of the following ways:
  - Fax to (866)286-1086 (notifications and prior authorization requests)

Molina Prior Authorization Requests

- BH Prior Authorization request form is located at: www.molinahealthcare.com/providers/wa/medicaid/Pages/home.aspx
  - CLICK – forms in the menu, then Frequently Used Forms from the dropdown menu
- Molina Behavioral Health Prior Authorization Guide:
  - Located within the Provider Web Portal: https://provider.molinahealthcare.com/provider/login
- Molina Prior Authorization by CPT Code Guide
  - Provides prior authorization requirements based on specific procedure code, place of service, etc. Available via the Provider Web Portal: https://provider.molinahealthcare.com/provider/login

Molina BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal

To fax in a request for services:

- Prior Authorization Fax: (800) 767-7188

To check the status of a request or get assistance with an authorization:

- Healthcare Services (Prior Authorization): (800) 869-7175

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact BH UM management:

Denise Kohler, LICSW
Manager BH UM Team
800-869-7175 Ext. 140257

Laurie McCraney RN MBA
Director, Healthcare Services
Desk: 425-354-1572

United Healthcare BH Prior Authorization Methods

Call

- United HealthCare Call Center: (877) 542-9231
- IP & Res reviews 24/7
- Non-Routine Outpatient: Call during business hours

Online
Preferred method of submission

- Available: https://www.uhcprovider.com/en/prior-auth-advance-notification.html
- Frequently used non-routine services where an authorization can be requested online include: Psychological Testing, Transcranial Magnetic Stimulation (TMS), GFS funded services and ABA/Autism
- For other non-routine services call the number on the back of the Member's ID card to request authorization.

Fax

- IMC Fax Form available and to: (844) 747-9828

United Healthcare BH Prior Authorization Contacts

To request an authorization or check the status of a request:

- Provider Web Portal: Providerexpress.com
- Healthcare Services (Prior Authorization): (877) 542-9231

To fax in a request for services:

- Prior Authorization Fax: (844) 747-9828

For any prior authorization escalated issues that cannot be resolved through the prior authorization line, contact:

Region	Network Contact	Email	Phone
Thurston Mason/ Great Rivers	Renee (Randi) Johnson	Randi.Johnson@Optum.com	(425)201-7106

Program Integrity and Monitoring

Program Integrity and Monitoring • WISe • Member Grievance and Appeal • Critical Incidents • Behavioral Health Ombudsman

Program Integrity

- Detection, prevention, mitigation, and investigation of Fraud, Waste, and Abuse (FWA)—we all strive to consistently be good stewards of public dollars and ensure proper care is being delivered to our members.
- **Prevent**—we use data mining algorithms to detect and prevent potential wasteful or abusive billing
  - **Examples:** Incorrect coding, misalignment with CMS requirements for the Medicaid program, or lack of medical necessity for the service being provided
  - Through prevention activities, claims are denied before being paid and MCO staff reach out to ***educate*** on proper billing practices
- **Mitigation and Recovery—**we also use data mining algorithms on *paid* claims to detect for FWA and improperly paid claims or claims paid against medical necessity; we work with the provider to recover the funds that were improperly paid and educate on reasons why and future prevention
- **Investigation—**Each MCO has investigation units to investigate potential fraud and/or abuse activities; if activities are found, we are required to report individual providers or provider agencies to HCA and CMS

Monitoring

All MCOs complete the following monitoring which may result in chart reviews and periodic auditing activities:

- Quality of Care Issues
- Critical Incident Investigations
- Over and Under Utilization Monitoring
- “HEDIS season” chart requests
- Utilization Management
- Annual training attestations (joint MCO training available)
  - Enrollee Rights and Responsibilities
  - Advance Directives
  - Fraud, Waste, and Abuse
  - False Claims Act

WISe Notification Form

- Notification Form should be completed for the following reasons:
  - Enrollment of new WISe client
  - Adverse Benefit Determination (ABD)
    - WISe Provider determines the following:
      - Denial
      - Termination
      - Reduction of Services
      - Suspension

Refer to WISe Manual for detailed descriptions of ABDs

WISe Tracker

- Monthly report due by 5th of month
  - Enrollment: Number of WISe members in the program during the month.
  - Service Intensity: Average number of services your WISe enrollees received during the month.
  - Interest List: Members who have been screened but are waiting to get into WISe.

MCOs will be outreaching to Providers to discuss expectations and procedures in greater detail.

Member Grievance and Appeal

- A Member may express dissatisfaction pertaining to quality of care, the way the member was treated, problems getting care and billing issues.
  - Member should be referred to their MCO to report a grievance. **Only members can file a grievance**, or designate someone to file on their behalf with written authorization.
  - MCO will confirm receipt of the grievance within two business days of receipt.
  - Grievances are resolved within 45 days and the Member will be advised of the resolution.
- A Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial.
  - For WISe appeals, please follow the WISe Manual.

How Can a Member Report a Grievance or Request an Appeal?

MCO	Contact Number	Email
Amerigroup	(800) 600-4441	WA-Grievance@Amerigroup.com
Coordinated Care	(877) 644-4613	WAQualityDept@Centene.com
Molina Healthcare	(800) 869-7165	MHWMemberServicesWeb@ MolinaHealthcare.com
UnitedHealthcare Community Plan	(866) 556-8166	WACS_Appeals@UHC.com

Please refer to MCO Provider Manuals for additional information on the Member Grievance and Appeal process.

Critical Incidents

Definition	Who?
Critical Incident is an event involving a member with impact to health and safety.	Anyone (member, provider, MCO staff, etc.) may identify and report a Critical Incident.

- An event may lead to both a Critical Incident and/or Grievance, but they are separate reports and systems based on the definitions.
- In addition to HCA and MCO requirements, providers are also responsible for maintaining incident and grievance/complaint reporting systems as outlined In WAC and RCW appropriate to their agency and facility licensure.

Critical Incident - Individual vs Population Based Reporting

- HCA provides a category list of incidents to be submitted by the MCO in the Incident Reporting System within one (1) business day.
- Additional events are tracked, monitored, and investigated for Population Based reporting, submitted to HCA by MCO biannually.
  - Review of trends in categories, demographics, etc.
  - Report on efforts in follow-up and prevention actions
- Providers submit Critical Incident reports to MCOs for Individual and Population-Based reporting categories or requirements as requested.

HCA Individual Incident Reporting Categories

The following incidents should be reported if they occurred **to an Enrollee** within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider:

- Abuse, neglect or sexual/financial exploitation; and
- Death.

HCA Individual Incident Reporting Categories

By an Enrollee, with a behavioral health diagnosis; or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:

- Homicide or attempted homicide;
- Arson;
- Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;
- Kidnapping;
- Sexual Assault;
- Unauthorized leave from a behavioral health facility during an involuntary detention; and
- Any event involving an Enrollee that has attracted or is likely to attract media coverage.

Critical Incident Reporting Process

Critical Incident Occurs
- Provider notifies MCO of incident using Critical Incident Report Form within one (1) business day of reporter's awareness of the incident.

Critical Incident is Reported
- MCO enters incident into Incident Reporting System by COB on the date received from the reporter.

Critical Incident is Closed
- MCO completes investigation and follow-up and enters into the Incident Reporting System. HCA may request additional follow-up from the MCO.

Population-Based Reporting Categories

MCOs submit a semi-annual report of all Critical Incidents tracked during the previous six months, which includes analysis of the following:

- Incidents reported through the HCA Individual Reporting System;
- Incidents posing a credible threat to Enrollee safety;
- Suicide and attempted suicide; and
- Poisonings/overdoses unintentional or intention unknown.

Where to Report a Critical Incident

The Critical Incident Form are available on each MCO's website and to be submitted to the emails listed.

MCO	Email
Amerigroup	QMNotification@Anthem.com
Coordinated Care	WABHcriticalincidents@CoordinatedCareHealth.com
Molina Healthcare	MHW_Critical_Incidents@MolinaHealthcare.com
UnitedHealthcare Community Plan	WA_Criticalinc@UHC.com

Behavioral Health Ombudsman

- The Ombuds service:
  - receives, investigates, advocates for, and assists eligible individuals with the resolution of grievances, the appeal processes when applicable, and, if necessary, the administrative fair hearing process;
  - is responsive to the age and demographic character of the region and assists and advocates for individuals with resolving issues, grievances, and appeals at the lowest possible level;
  - is independent of service providers; and
  - coordinates and collaborates with allied services to improve the effectiveness of advocacy and reduce duplication.
- Behavioral Health Ombuds members must be current consumers of the mental health or substance use disorder system, or past consumers or family members of past consumers.

Behavioral Health Ombudsman

Region	Contact Information
Thurston Mason Ombuds	Phone: 1-800-658-4105 or 360-763-5793 Address: 612 Woodland Square Loop SE, #401 Lacey, WA 98503 Fax: 360-584-9745
Great Rivers Ombuds	Cowlitz, Pacific and Wahkiakum Counties Phone: 1-866-731-7403 or 360-414-0237 Lewis and Grays Harbor Counties Phone: 1-833-721-6011 or 360-266-7578

Resources

HCA Interpreter Services • HCA Transportation Brokers • Frequently Used Forms • Helpful Links

HCA Interpreter Services

The HCA Interpreter Services (IS) program is available to healthcare providers serving limited English proficient (LEP), Deaf, DeafBlind, and Hard of Hearing Medicaid clients and individuals applying for or receiving DSHS or DCYF services.

You must register an HCA account with Universal in order to request an interpreter.

- Universal will train providers how to access an interpreter using their online service portal.

Services will only be covered by the HCA IS program if:

- The client is current Medicaid eligible
- The client is enrolled in a Managed Care plan (IMC eligible)
- Services are covered in their benefit package
- Services are provided by an HCA enrolled Medicaid Provider

HCA Transportation Brokers

- Medicaid clients may be eligible for non-emergency medical transportation, which can be arranged and paid for Medicaid clients with no other means to access medical care through HCA contracted brokers listed below. 7-14 days advance notice is recommended.
- The HCA Non-Emergency Medical Transportation (NEMT) program now allows non-emergency transportation for all clients going to and/or from SUD or MH facilities for any length of stay.

HCA Transportation Brokers

Transportation Broker		
Region	Broker	Contact
Thurston Mason	Paratransit Services	360-377-7007 1-800-846-5438 TDD/TTY: 1-800-934-5438
Great Rivers *Grays Harbor, Lewis and Pacific Counties*	Paratransit Services	360-377-7007 1-800-846-5438 TDD/TTY: 1-800-934-5438
Cowlitz and Wahkiakum Counties	Human Services Council	360-694-9997 1-800-752-9422

Frequently Used Forms

Available on MCO websites:

- PCP Change
- Critical Incident Report
- Release of Information/Authorization for Use and Disclosure of PHI
- Prior Authorization/Concurrent Review Request
- BH Prior Authorization/Concurrent Review Request
- Care Management Referral
- Appeal Consent

Helpful Links

- Provider Manuals
  - Amerigroup: https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf
  - Coordinated Care: https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
  - Molina Healthcare: http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman.aspx
  - UnitedHealthcare Community Plan: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/stateAddendums/waIMC-NetworkManual.pdf
- WISe Manual: https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
- SERI: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri
- HCA Billing Guides: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Questions and Answers

Thank you for joining us today!